

068608 OCT 15 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

29410

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Tom Brown</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>9 18 87</i>		2b. HOUR M <i></i>
3. SEX <i>male</i>	4. RACE <i>Black</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>2 23 1901</i>		6. AGE (IN YEARS (LAST BIRTHDAY)) YRS <i>86</i>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN <i></i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Miss.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Caroline</i> MD	
10. CITY OR TOWN OF DEATH <i>Denton</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Home</i>		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <i>laborer</i>	12b. KIND OF BUSINESS OR INDUSTRY <i></i>	
13a. STATE <i>md</i>		13b. COUNTY <i>Caroline</i>	13c. CITY OR TOWN <i>Denton</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>603 Riverview Garden 21629</i>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Ned Brown</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Hattie Williams</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>489-26-22</i>	
16b. SOCIAL SECURITY NO <i>489-26-22</i>		17. INFORMANT <i>Mary Thomas Preston, md 21655</i>		ADDRESS <i>Rt #2</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASHD + HCVD.</i> 2-3 yrs (c) <i>Atherosclerosis - nephrosclerosis 5 yrs.</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Chronic Bronchitis 2° to smoking</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>11/29 1980</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <i>9/14</i> 19 <i>87</i> to <i>9/18</i> 19 <i>87</i> that (I) <del>was</del> last saw the deceased alive on <i>9/14</i> 19 <i>87</i> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>John F. McCarthy</i>		DEGREE <i>MD</i>		22c. DATE SIGNED	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DR. JOHN F. MCCARTHY MD</i>		22f. ADDRESS <i>Rt. 1 Box 288-A Greensboro, MD 21639</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>9-22-87</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Pennacast Church</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Bethesda Caroline Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Blenne Smith</i>		ADDRESS <i>P.O. Box 928 Haverhill, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>OCT 14 1987</i>	
				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other fatal condition, the medical examiner must be notified at once.

06880 OCT 12 87

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED

DATE 11/17/00 BY SP8 PJS/BJ

069799 OCT 23 87

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

2941

1. DECEASED-NAME (Type or print) James Perry Brumbaugh, II			2a. DATE OF DEATH Month Day Year October 15, 1987			2b. HOUR 2:45 PM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH Sept. 18, 1928		6. AGE (In years last birthday) 59 YRS.	
7a. BIRTHPLACE (State or foreign country) Washington DC		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Caroline County Md.	
10. CITY OR TOWN OF DEATH Denton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 106 S. Seventh St.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Self-employed		12b. KIND OF BUSINESS OR INDUSTRY Business	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Caroline		13c. CITY OR TOWN Denton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 21629		13f. STREET AND NUMBER 106 South Seventh St.					
14. FATHER'S NAME First Middle Last James Perry Brumbaugh			15. MOTHER'S MAIDEN NAME First Middle Last Lydia Lois Withers				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. 51-53		17. INFORMANT Rev. Lillian Brumbaugh, Denton, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RECTAL CARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 MONTHS</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (1) (this hospital) attended the deceased from <u>12/10</u> , 19 <u>86</u> , to <u>10/15</u> , 19 <u>87</u> , that (1) (we) lost the deceased alive on <u>10/13</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Ludwig J. Glesner, M.D.</u>				DEGREE ATTENDING PHYS.		22c. DATE SIGNED <u>10/26/87</u>	
22d. PHYSICIAN'S NAME (Type) <u>Ludwig J. Glesner, M.D.</u>				22e. ADDRESS <u>RT 3 Box 106 Easton MD 21601</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>OCT. 17, 1987</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GEORGE WASHINGTON</u>		23d. LOCATION (City or Town) (County) (State) <u>RIGGS Rd PRINCEGEORGES MD</u>	
24. FUNERAL DIRECTOR <u>Franklin Moore 1252 1/2 St. Deale, Md</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 19 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DEC 10 1933

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

NOV 10 1933

TO THE DIRECTOR, BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

FROM THE DIRECTOR, BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

SUBJECT: [Illegible]

[The remainder of the page contains several paragraphs of extremely faint, illegible text, likely a memorandum or report.]

070158 OCT 29 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

29412

REG NO

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Allmon William Hamilton, Jr.				2a DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 10 17 87		2b HOUR M
3 SEX Male	4 RACE Cauca.	5 DATE OF BIRTH MONTH DAY YEAR 5 13 1925	6 AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN 62 YRS	7c DATE PRONOUNCED DEAD MONTH DAY YEAR 10 18 87	7d HOUR 12:40 PM	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U. S. A.		9 BALTIMORE CITY OR COUNTY OF DEATH Caroline County MD		
10 CITY OR TOWN OF DEATH Denton		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Tuckahoe Neck Road		12a USUAL OCCUPATION (TYPE OF WORK) FOR MOST OF WORKING LIFE Carpenter		
13a STATE Maryland		13b COUNTY Caroline	13c CITY OR TOWN Denton	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Allmon William Hamilton, Sr.		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Andrew				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO. 218202899		17 INFORMANT ADDRESS Ronald Hamilton, Denton, MD		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gun shot wound - chest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .						
ACTUAL SIGNATURE <u>H. R. Trapnell</u>		TITLE (SPECIFY) M.D. <u>ent. dr. 5</u>		DATE SIGNED 10-20-87		
EXAMINER'S NAME (TYPE OR PRINT) <u>H. R. Trapnell, M.D.</u>		ADDRESS <u>128 Bloomingdale Avenue</u> <u>Federalburg, Maryland 21632</u>				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/20/87	23c NAME OF CEMETERY OR CREMATORY Concord Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Denton Caroline Maryland	
24 FUNERAL DIRECTOR NAME Moore Funeral Home, 12 S2nd St. Denton		25a DATE REC'D. BY REGISTRAR 10/27/1987		25b REGISTRAR'S SIGNATURE <u>W. Gordon Hordell</u>		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE REASON IN ITEM 19, AND RETURN TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM TM-3, RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 27 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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COLL 10 100

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

DECEASED NAME (TYPE OR PRINT) FIRST <u>Carmen</u> MIDDLE <u>Ford</u> LAST <u>Ford</u>			2a DATE OF DEATH MONTH <u>10</u> DAY <u>18</u> YEAR <u>87</u>		2b HOUR <u>2:50</u> <u>A</u>
3 SEX <u>Female</u>	4 RACE <u>White</u>	5. DATE OF BIRTH MONTH <u>2</u> DAY <u>27</u> YEAR <u>03</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>84</u> YRS	IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>UNK.</u>	7b CITIZEN OF WHAT COUNTRY? <u>USA</u>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>Caroline</u> MD	
10 CITY OR TOWN OF DEATH <u>Denton</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Wesleyan HealthCare Center</u>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY
13a STATE <u>MD.</u>		13b COUNTY <u>CAMBRIDGE</u>	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST <u>UNK.</u> MIDDLE <u></u> LAST <u></u>		15 MOTHER'S MAIDEN NAME FIRST <u>UNK.</u> MIDDLE <u></u> LAST <u></u>		13e STREET ADDRESS / ZIP CODE <u>520 GLENBURN AVE.</u> <u>21613</u>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>UNK.</u>		16b SOCIAL SECURITY NO. <u>213-74-2418</u>		17 INFORMANT <u>Ernest Cookery-attorney</u> <u>778-2112</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Malnutrition (Refusing foods)</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic illness</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CHF</u> // <u>Supraventricular arrhythmia</u> // <u>Gangrene of the feet</u>					
19a DATE OF OPERATION <u></u>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <u></u>		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING, OR CONTRIBUTING, CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NO</u>		21b TIME OF INJURY HOUR <u></u> A.M. MONTH <u></u> DAY <u>19</u> P.M.		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u></u>	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u></u>		21f LOCATION STREET <u></u> CITY OR TOWN <u></u> COUNTY <u></u> STATE <u></u>	
22a I certify that (1) this hospital attended the deceased from <u>April 1, 1983</u> to <u>1987</u> that (2) we last saw the deceased alive on <u>October 18, 1987</u> and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)					
22b SIGNATURE <u>Monica Agree MD</u>				22c DATE SIGNED <u>10/26/01</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>Monica Agree MD</u>				22e ADDRESS <u>Denton, MD 21629</u>	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		23b DATE <u>10-18-87</u>		23c NAME OF CEMETERY OR CREMATORY	
24 FUNERAL DIRECTOR NAME <u>State Anatomy Board</u>		ADDRESS <u>Balto., Md.</u>		25a DATE REC'D BY REGISTRAR <u>OCT 19 1987</u>	
				25b REGISTRAR'S SIGNATURE <u>Jana Davidson-Randall</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00214 OCT 21 97

068755 OCT 16 1987

FOR  
STATE  
REGISTRARItems #5 & #6,  
Form G640, 6/7/88, ed1STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

29414

1 DECEASED NAME (TYPE OR PRINT) JAMES EDWARD GRIFFIN			2a DATE OF DEATH MONTH DAY YEAR 10/9/87			2b HOUR 7:46 PM			
3 SEX MALE		4 RACE BLACK		5 DATE OF BIRTH MONTH DAY YEAR 10 20-1923		6 AGE (IN YEARS LAST BIRTHDAY) 63* 6-0-- YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.		7b CITIZEN OF WHAT COUNTRY? U.S.A		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH CAROLINE MD			
10 CITY OR TOWN OF DEATH DENTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WESLEYAN HEALTH CARE				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABOR		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE MD.		13b COUNTY Kent		13c CITY OR TOWN Chestertown		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 416 CALVERT ST.	
14 FATHER'S NAME FIRST MIDDLE LAST JAMES GRIFFIN		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LEOLA SPRUILL		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 721-18-6388		17 INFORMANT ADDRESS MRS. LEOLA GRIFFIN R. #1 CHESTERTOWN, MD. 21621	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Aspiration</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> <u>&lt;10 min</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Rheumatoid arthritis</u>									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>7</u> 19 <u>87</u> to <u>10</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>7/25</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b SIGNATURE <u>Andrea Allen MD</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED	
22d PHYSICIAN'S NAME (TYPE OR PRINT) ANDREA ALLEN MD						22e ADDRESS			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b DATE 10-15-1987		23c NAME OF CEMETERY OR CREMATORY MALE-FEMALE BEN		23d LOCATION CITY OR TOWN COUNTY STATE CHESTERTOWN Kent MD		
24 FUNERAL DIRECTOR NAME Zemath Wally						25a DATE REC'D BY REGISTRAR OCT 15 1987			
25b REGISTRAR'S SIGNATURE John Gordon-Rodell									

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VRA 15, 4)

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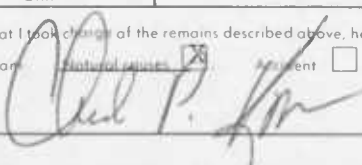
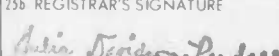
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

29118

1. DECEASED NAME (TYPE OR PRINT) GERALDINE F. HOWARD										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10 25 19 87		7b. HOUR M 6:15 PM					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 - 22 - 31		6. AGE (IN YEARS) (LAST BIRTHDAY) 56 YRS		IF UNDER 1 YR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 26 19 87		7d. HOUR M 6:15 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Caroline County MD					
10. CITY OR TOWN OF DEATH Ridgely				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) (auto)-108 Central Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker				12b. KIND OF BUSINESS OR INDUSTRY Home					
13a. STATE Maryland										13b. COUNTY Caroline		13c. CITY OR TOWN Ridgely		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 108 Central Ave. 21660	
14. FATHER'S NAME FIRST MIDDLE LAST Howard Ferrick										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Harriett Ireland							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-28-8111				17. INFORMANT Dawn P. Coursey				ADDRESS Denton, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intracerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 10-27-87					
EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D.				ADDRESS 111 Penn St., Balto., MD 21201													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 10-30-87		23c. NAME OF CEMETERY OR CREMATORY Ridgely Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Ridgely CA MD							
24. FUNERAL DIRECTOR NAME John E. Boulais				ADDRESS Greensboro, MD				25a. DATE REC'D. BY REGISTRAR NOV 03 1987				25b. REGISTRAR'S SIGNATURE 					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Cora K. Minner</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>10/1/87</b>			2b. HOUR <b>7:45 AM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 6, 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 1 HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Delaware</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Caroline</b> MD			
10. CITY OR TOWN OF DEATH <b>Denton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Wesleyan Health Care Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Caroline</b>		13c. CITY OR TOWN <b>Greensboro</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Riverview Lane 21639</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert Kemp</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Cora Bell</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>219-07-1194</b>		17. INFORMANT <b>Virginia Twilley</b>			ADDRESS <b>Houston, DE</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Congestion Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>Pneumonia, Osteoporosis</b>									
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>7/6/86</b> to <b>10/1/87</b> that (I) (we) last saw the deceased live on <b>9/11/87</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, and (I) (we) did not view the body after death.									
22b. SIGNATURE <b>Rob Lappin MD</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>10/1/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Rob Lappin MD</b>				22e. ADDRESS <b>CHS PO Box 120 Greensboro Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-3-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greensboro Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Greensboro CA MD</b>		23e. DATE REC'D. BY REGISTRAR <b>10 8 1987</b>	
24. FUNERAL DIRECTOR NAME <b>John E. Boulais</b>				ADDRESS <b>Greensboro, MD</b>		25a. REGISTRAR'S SIGNATURE <b>Davidson</b>		25b. REGISTRAR'S SIGNATURE	

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08 FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

29417

1 DECEASED NAME (TYPE OR PRINT)			2a DATE OF DEATH			2b HOUR		
Charles A. Perry			10 - 27 - 87			7:55 a		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE			7b HOUR		
Male	White	2 - 2 - 03	84					
7a BIRTHPLACE (COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			
New York	USA				Caroline MD			
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY	
Goldsboro	State Rte. 313			Plumber			Plumbing	
13a STATE		13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS / ZIP CODE			
Maryland		Caroline	Goldsboro	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	State Rte. 313			21636
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME					
John Perry			Mary ?					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS				
no		107-09-2776		Bessie F. Perry Goldsboro, MD				
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last } (b) <u>Carcinoma of Colon +</u> DUE TO, OR AS A CONSEQUENCE OF <u>Liver</u> (c) <u>liver</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1-2 mo</u>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>COPD ASHD</u>								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NUMBER OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION (STREET CITY OR TOWN COUNTY STATE)				
22a I certify that (1) this hospital attended the deceased from <u>July</u> 19 <u>83</u> to <u>Sept</u> 19 <u>87</u> that (2) I last saw the deceased alive on <u>Sept 14</u> 19 <u>87</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated								
22b SIGNATURE				22c DEGREE			22c DATE SIGNED	
<u>John A. McCarthy</u>				MD			10-27-87	
22e PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS				
John A. McCarthy, M.D.				Greensboro, MD				
23a BURIAL, CREMATION, REMOVAL (SEE INSTRUCTIONS)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (CITY OR TOWN COUNTY STATE)		
Burial		10-31-87		Halsey Cemetery		Halsey Valley Tioga NY		
24 FUNERAL DIRECTOR NAME				25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
John E. Boulais				Greensboro, MD		NOV 03 1987 <u>Alia Tridman-Pendley</u>		

MEDICAL CERTIFICATION

5

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9

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DHMH - 16 60M 7-84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that a death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the medical examiner and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the permit from the certificate and return it to the State Dept. of Health and Mental Hygiene prior to burial or cremation.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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